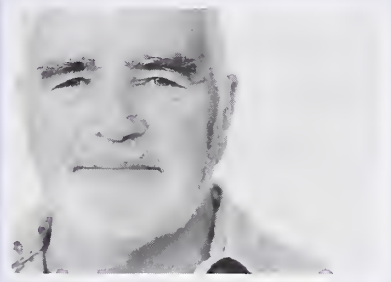
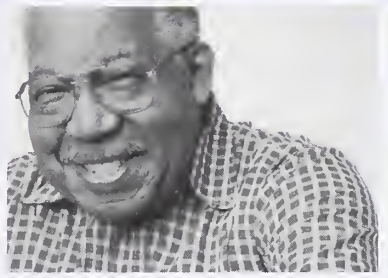
Medicare and Home Health Care





This is the official government booklet that explains . . .

- **How to find and compare home health agencies.**
- **The Medicare home health benefit and who is eligible.**
- **What is covered by the Original Medicare Plan.**
- **Where you can get more help with questions.**

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CENTERS for MEDICARE & MEDICAID SERVICES

Welcome

Medicare and Home Health Care is designed to help people find and compare home health agencies. It can help you and your family choose the agency that is best for you. It includes important information about eligibility for Medicare coverage of home health care, what Medicare does and doesn't cover, quality of care, and resources for more information.

Medicare and Home Health Care is prepared by the Centers for Medicare & Medicaid Services (CMS). CMS and States oversee the quality of care provided by home health agencies. State and Federal Government agencies certify home health agencies.

Medicare and Home Health Care is not a legal document.
The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

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Home health services are given by a variety of skilled health care professionals at home.

1 - What is Home Health Care?

Home health care includes skilled nursing care, as well as other skilled care services, like physical and occupational therapy, speech-language therapy, and medical social services. These services are given by a variety of skilled health care professionals at home.

The home health staff provides and helps coordinate the care and/or therapy your doctor orders. Along with the doctor, home health staff create a plan of care, which is a written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well-being. The home health staff keeps your doctor up-to-date on how you are doing and updates your plan of care as needed, as authorized by your doctor. More information about plans of care can be found on pages 19 and 20.

The need for home health care has grown for many reasons. Medical science and technology have improved. Many treatments that could once be done only in a hospital can now be done at home. Also, home health care is usually less expensive and can often be just as effective as care in a hospital or skilled nursing facility. And just as important, most patients and their families prefer to stay at home rather than be in a hospital or a nursing home.

While you get home health care, home health staff teach you (and your caregiver) to continue any care you may need, including medication, wound care, therapy, and stress management. Since most home health care is intermittent and part-time, you (and your informal caregivers) should learn how to identify and care for possible problems, like confusion or shortness of breath.

The goal of short-term home health care is to provide treatment for an illness or injury. It helps you get better, regain your independence, and become as self-sufficient as possible. The goal of long-term home health care (for chronically ill or disabled people) is to maintain your highest level of ability or health, and help you learn to live with your illness or disability.

Words in blue are defined on pages 26–27.

Look at "Home Health Compare" on www.medicare.gov for information about home health agencies in your area.

2 - Choosing a Home Health Agency

How do I find a Medicare-approved home health agency?

You can find a Medicare-approved home health agency by

- looking at "Home Health Compare" on www.medicare.gov on the web. Home Health Compare provides the
    - name and office address of the agency,
    - agency phone number,
    - services offered by the agency (such as nursing care, physical therapy, occupational therapy, speech-language pathology, medical/social services, and home health aide),
    - agency's initial date of Medicare certification,
    - type of ownership (For Profit, Government, Non-Profit), and
    - quality measures (see page 6).
- asking your doctor, hospital discharge planner, or social worker. Or, ask friends or family about their home health care experiences.
- using a senior community referral service, or other community agencies that help you with your health care.
- looking in your telephone directory in the Yellow Pages under "home care" or "home health care."

Note: A home health agency has the right to refuse to accept any individual patient if it is unable to meet the patient's needs.

2 - Choosing a Home Health Agency

Information About Home Health Quality Measures

Quality care means doing the right thing, at the right time, in the right way, for the right person, and having the best possible results. Home health agencies are certified to make sure they meet certain Federal health and safety requirements. To find out how home health agencies compare in quality, look at www.medicare.gov on the web. Select "Home Health Compare."

These quality measures give you information about how well home health agencies provide care for their patients. The measures provide information about patients' physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. This quality information helps you compare and ask questions of home health agencies.

The quality measures relate to

- improvement in getting around,
- activities of daily living, like bathing, dressing, using the bathroom, or eating,
- patient medical emergencies, and
- improvement in mental health.

You can also get information about home health agencies from your State Survey Agency. Ask them for the state survey report on the home health agency of interest to you. Call 1-800-MEDICARE (1-800-633-4227) or look on www.medicare.gov on the web to get their telephone number. In some cases, your local long-term care ombudsman may have information on the home health agencies in your area. You can find local Long-term Care Ombudsmen at www.ltcombudsman.org or by calling the Eldercare Locator at 1-800-677-1116.

Words in blue are defined on pages 26–27.

2 - Choosing a Home Health Agency

Home Health Agency Checklist

Use this checklist to help you compare and choose a home health agency.

Name and Location of Home Health Agency _____

_____

_____

The Agency:	Yes	No	Comments
1. Is Medicare-certified.			
2. Is Medicaid-certified.			
3. Offers the specific health care services I need (like nursing or physical therapy).			
4. Meets my special needs (like language or cultural preference).			
5. Offers the personal care services I need (like help bathing, dressing, and using the bathroom).			
6. Offers the support services I need (like help with laundry, cooking, shopping, or housekeeping), or can help me arrange for additional services, such as Meals on Wheels, that I may need.			
7. Has staff available to provide the type and hours of care my doctor ordered, and can start when I need them.			
8. Is recommended by my hospital discharge planner, doctor, or social worker.			
9. Has staff available at night and on weekends for emergencies.			
10. Explained what my insurance will cover, and what I must pay out-of-pocket.			
11. Does background checks on all staff.			
12. Has letters from satisfied patients, family members, and doctors that testify to the home health agency staff providing good care.			

2 - Choosing a Home Health Agency

Do I have a choice in which home health agency I use?

If your doctor decides you need home health care, you have the right to choose a home health agency to give you the care and services you need. Your choice should be honored by your doctor, hospital discharge planner, or other referring agency. Although you have a say in which agency you use, your choices may be limited by agency availability, or by Medicare's rules. It is important to remember that Medicare only pays for home health services that are given by a home health agency that meets Medicare's standards and is approved (certified) by Medicare. Medicare regularly inspects home health agencies to make sure that these standards are met.

Some hospitals have their own home health agency. You don't have to choose the hospital's agency. You may choose any Medicare-certified agency that you feel will meet your medical needs.

Your home health agency must provide you with all the home care identified in your plan of care (see page 19–20), including staff services and medical supplies. The agency may do this through its own staff, through an arrangement with another agency, or by hiring nurses, therapists, home health aides, and medical social service counselors to meet your needs.

Medicare Advantage is the new name for Medicare + Choice. If you are in a Medicare Advantage Plan (like a Medicare Managed Care Plan), you may have to use a home health agency that works with the plan. See page 16 for more information about Medicare Advantage Plans.

When you start getting home care, staff from the Medicare-approved home health agency will ask you some questions about your health to help them give you proper care. The home health agency is required to keep your information confidential. You may ask to see this information. The home health agency will explain these questions to you, and give you written information about your right to privacy.

Most Medicare-certified home health agencies will accept all Medicare patients. An agency is not required to accept a patient if it can't meet the patient's medical needs. An agency can't refuse to take a specific patient because of the patient's condition, unless the agency also refuses to take other people with the same condition.

Words in blue are defined on pages 26–27.

2 - Choosing a Home Health Agency

What if I want to change home health agencies?

Medicare will only pay for you to get care from one home health agency at a time. You may decide to end your relationship with one agency and choose another at any time. Contact your doctor to get a referral to a new agency. You must tell both the agency you are leaving and the new agency you choose that you are changing home health agencies.

Home health aide services are covered if you are also getting Medicare-covered skilled care.

3 - Medicare Coverage of Home Health Care

Who is eligible to get Medicare-covered home health care?

If you have Medicare, you can use your home health care benefits if you meet **all** the following conditions.

1. Your doctor must decide that you need medical care at home, and make a plan for your care at home.
2. You must need at least one of the following: intermittent skilled nursing care, or physical therapy, or speech-language therapy, or continue to need occupational therapy.
3. The home health agency caring for you must be approved by the Medicare program (Medicare-certified).
4. You must be homebound, or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

Eligibility is also based on the amount of services you need.

Medicare covers your home health services for as long as you are eligible and your doctor says you need these services. However, the skilled nursing care and home health aide services are only covered on a part-time or "intermittent" basis. This means there are limits on the number of hours per day and days per week that you can get skilled nursing or home health aide services. Therapy services don't have to be part-time or intermittent.

Words in blue are defined on pages 26–27.

To decide whether or not you are eligible for home health care, Medicare defines part time or "intermittent" as skilled nursing care that is needed or given on fewer than seven days each week or less than eight hours each day over a period of 21 days (or less) with some exceptions in special circumstances. See example on the next page.

3 - Medicare Coverage of Home Health Care

For example, Jane's doctor says that she needs a nurse to visit her every day for the next 15 days to care for a wound. The skilled wound care that is ordered by the doctor is medically reasonable and necessary for the treatment of Jane's wound. The total time that the nurse will be at Jane's house will be less than an hour each day. Jane only needs the nurse to come for 15 days. Jane's need for home health care meets the Medicare definition of "intermittent."

Hour and day limits may be extended in exceptional circumstances when your doctor can predict when your need for care will end.

Once you are getting home health care, Medicare defines part-time or intermittent as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week. Based on your need for care, on a case-by-case basis, the weekly total may be increased to up to 35 hours. This definition helps Medicare make decisions about your coverage.

For example, Fred has been getting home health care for 3 weeks. Fred's condition is improving, but his doctor determines that Fred continues to need home health care. Fred's doctor says that he needs a nurse to come in 4 days a week for 3 hours each day (a total of 12 hours) and a home health aide to come in 5 days a week for 3 hours each day (a total of 15 hours). This means that Fred is getting a total of 27 hours of home care per week. This meets Medicare's definition of "part-time or intermittent" home health care.

3 - Medicare Coverage of Home Health Care

What home health services does Medicare cover?

If you meet all four of the conditions for home health care, (listed at the top of page 11) Medicare will cover

- skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
- home health aide services on a part-time or intermittent basis. A home health aide doesn't have a nursing license. The aide provides services that give additional support to the nurse. These services include help with personal care such as bathing, using the bathroom, or dressing. These types of services don't need the skills of a licensed nurse. Medicare doesn't cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.
- physical therapy, speech-language therapy, and occupational therapy for as long as your doctor says you need it.
    1) **Physical therapy**: including exercise to regain movement and strength in a body area, and training on how to use special equipment or do daily activities, like how to get in and out of a wheelchair or bathtub.
    2) **Speech-language therapy** (pathology services): including exercise to regain and strengthen speech skills.
    3) **Occupational therapy**: to help you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. You may continue to receive occupational therapy even if you no longer need other skilled care if ordered by your doctor.
- medical social services to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.
- certain medical supplies like wound dressings, but not prescription drugs or biologicals.
- durable medical equipment such as a wheelchair or walker.
- FDA (Food and Drug Administration) approved injectable osteoporosis drugs in certain circumstances.

What doesn't Medicare cover for home health care?

Medicare doesn't pay for

- 24-hour-a-day care at home;
- prescription drugs;
- meals delivered to your home;
- homemaker services like shopping, cleaning, and laundry; and
- personal care given by home health aides like bathing, dressing, and using the bathroom **when this is the only care you need.**

Although Medicare doesn't cover prescription drugs as part of home health care, a recent law added new prescription drug benefits to the Medicare program as a whole. Under the new law, all people with Medicare will be able to enroll in plans that cover prescription drugs. In 2004, Medicare-approved drug discount cards were made available to help you save on perscription drugs. In 2006, a prescription drug benefit will be added to Medicare that pays some, but not all, of your prescription drug costs.

People with Medicare are either in the Original Medicare Plan or are enrolled in another Medicare health plan such as a Medicare Managed Care Plan, Medicare Preferred Provider Organization, or a Medicare Private Fee-for-Service Plan.

What does the Original Medicare Plan pay for?

The Original Medicare Plan pays the full Medicare-approved amount (cost) of all covered home health services. The home health agency sends bills to Medicare. Before your care begins, the home health agency must tell you how much of your bill Medicare will pay. The agency must also tell you if any items or services they give you are not covered by Medicare, and how much you will have to pay for them. This must be explained both by talking with you and in writing.

Words in blue are defined on pages 26–27.

What may I be billed for?

You may be billed for

- medical services and supplies that Medicare doesn't pay for, such as prescription drugs, and
- 20 percent of the Medicare-approved amount for Medicare-covered medical equipment such as wheelchairs, walkers, and oxygen equipment. If the home health agency doesn't supply durable medical equipment directly, the home health agency staff will arrange for a home equipment supplier to bring the items you need to your home.

3 - Medicare Coverage of Home Health Care

Note: If you are in the Original Medicare Plan, ask your supplier "Do you accept assignment?" Assignment could save you money. Call 1-800-MEDICARE (1-800-633-4227) and ask for a copy of *Does your doctor or supplier accept 'assignment'?*

How does the Original Medicare Plan pay for my home health care?

Medicare pays your home health agency a set amount of money for each 60 days that you need care. (This 60-day period is called an "episode of care.") The payment is based on what kind of health care an average person in your situation would need.

If a home health agency denies, cuts back, or stops your care because it believes that Medicare won't pay for home health care services that a doctor has ordered for you, the agency must give you a Home Health Advance Beneficiary Notice (HHABN). The HHABN should

- explain why the agency thinks that Medicare won't pay for the services,
- explain that you may have to pay for the services if Medicare doesn't pay for them, and
- give clear directions for getting an official decision from Medicare about the payment for home health services and for appealing the decision if payment is denied.

What do I do if the Original Medicare Plan stops paying for my home health care?

A home health agency must give you a HHABN that explains why and when it expects Medicare will stop paying for your home health care. If you get this notice and your doctor believes you still need home health care and that Medicare should keep paying, ask Medicare for an official decision.

To get an official decision, you must

- keep getting home health care if you think you need it. Ask how much it will cost. Talk to your doctor and family about this decision.
- understand you may have to pay the home health agency for these services.
- ask the home health agency in writing to send your claim to Medicare so that Medicare will decide if it will pay.

If the Original Medicare Plan decides to pay, you will get back all of your payments, except for any coinsurance for durable medical equipment and any other costs for things that Medicare doesn't cover.

What do I do if the Original Medicare Plan is not paying for an item or service that I think should be paid for?

If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or didn't pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill wasn't paid and what appeal steps you can take.

What if I am in a Medicare Advantage Plan?

Medicare Advantage Plans, such as a Medicare Managed Care Plan, a Medicare Preferred Provider Organization, or a Medicare Private Fee-for-Service Plan, are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Medicare health plans must cover all Medicare Part A and Part B health care, including home health care.

If you belong to a Medicare Advantage Plan, you may only be able to choose a home health agency that works with the health care plan. Call your plan if you have questions about the plan's home health care rules, coverage, appeal rights, and your costs. If you get services from a doctor or a home health agency that doesn't work with your Medicare Advantage Plan, neither the plan nor Medicare will pay the bill.

If you would like more information about Medicare health plans, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, look at your copy of the *Medicare & You* handbook mailed to all people with Medicare each fall.

Words in blue are defined on pages 26–27.

4 - How can Medicaid help people with low incomes?

State programs, like Medicaid, may help with medical costs for some people. To qualify, generally you must have a low income and few savings or other assets.

Medicaid coverage differs from State to State. In all States, Medicaid pays for basic home health care and medical equipment. Medicaid may pay for homemaker, personal care, and other services that aren't paid for by Medicare. States have programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income.

For more information about what Medicaid covers for home health care in your State, call your State medical assistance office. If you need the telephone number in your State, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your plan of care includes the kind of services you need, and what type of health care professionals should give these services.

5 - Your Home Health Care

Does a doctor oversee my home health care services?

Yes, your doctor will oversee your home health care by

- deciding you need care at home,
- developing your plan of care (see below), and
- communicating with the home health agency about your progress.

What is a plan of care?

A plan of care lists what kind of services and care you must get for your health problem. Your doctor will work with home health staff to decide

- what kind of services you need,
- what type of health care professional should give these services,
- how often you will need the services,
- the kind of home medical equipment you need,
- what kind of special foods you need, and
- what your doctor expects from your treatment.

Your doctor and home health agency staff review your plan of care as often as necessary, but at least once every 60 days. If your health problems change, your plan of care will be reviewed and may change. Home health agency staff must tell your doctor right away if your health changes. You will continue to get home health care as long as you are eligible.

Only your doctor can change your plan of care. Your home health agency can't change your plan of care without getting your doctor's approval. You must be told of any changes in your plan of care. If you have a question about your care, you should call your doctor.

(continued on page 20)

Words in blue are defined on pages 26–27.

What is a plan of care? (continued)

If your agency changes your plan of care without your doctor's approval, you have the right to appeal. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you how you can appeal.

If you feel your medical needs aren't being met, talk to both your doctor and the home health agency.

Words in blue are defined on pages 26–27.

5 - Your Home Health Care

Home Health Care Checklist

This checklist can help you and your family monitor your home health care. Use this checklist to help ensure that you are getting good quality home health care.

When I get my home health care	Yes	No	Comments
1. The staff is polite and treats me, and my family members, with respect.			
2. The staff explain my plan of care to me and my family, let us participate in creating the plan of care, and let us know ahead of time of any changes.			
3. The staff are properly trained and licensed to perform the type of health care I need.			
4. The agency explains what to do if I have a problem with the staff or the care I am getting.			
5. The agency responds quickly to my requests.			
6. The staff check my physical and emotional status at each visit.			
7. The staff respond quickly to changes in my health or behavior.			
8. My home is checked and suggestions are made to meet my special needs and to ensure my safety.			
9. The staff have told me what to do if I have an emergency.			
10. My privacy is protected.			

What can I do if I have a complaint about the quality of my home health care?

If you believe that the home health agency isn't giving you good quality care or you have a complaint about your home health agency, you should call your state home health hotline. Your home health agency should give you this number when you start getting home health services. Or, you can call the Quality Improvement Organization (QIO) in your State to file a complaint.

You can get local telephone numbers for the organizations that can help you on the "Helpful Contacts" section of the www.medicare.gov website, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How do I find and report fraud?

Most home health agencies are honest and use correct billing information. Unfortunately, fraud sometimes occurs. Fraud wastes Medicare dollars and takes money that could be used to pay claims. You are important in the fight to prevent fraud, waste, and abuse in the Medicare program.

To report Medicare fraud, call 1-800-447-TIPS (1-800-447-8477). You should look for

- home health visits that your doctor orders that you never get,
- visits by home health staff that aren't needed,
- bills for services and equipment you never get,
- faking of your signature or your doctor's signature,
- pressure to accept items and services that you don't need, and
- items listed on your Medicare Summary Notice that you don't think you received.

The best way to protect your home health benefit is to know what Medicare covers and to know what your doctor has planned for you. If you don't understand something in your plan of care, ask questions.

(continued on page 23)

How do I find and report fraud? (continued)

You also should be careful about activities such as

- home health services your doctor didn't order. The doctor who approves home health services for you should know you, and should be involved in your care. If your plan of care changes, make sure that your doctor was involved in making those changes.
- a home health agency that offers you free goods or services in exchange for your Medicare number. Treat your Medicare card like a credit card or cash. Never give your Medicare or Medicaid number to people who tell you a service is free, and they need your number for their records.

To report any suspected home health care fraud, call the Regional Home Health Intermediary for your State. You can get local telephone numbers for the organizations that can help you on the "Helpful Contacts" section of the www.medicare.gov website or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, call 1-800-447-TIPS (1-800-447-8477). Each call is taken seriously.

Words in blue are defined on pages 26–27.

You can get local telephone numbers for the organizations that can help you on the "Helpful Contacts" section of the www.medicare.gov website. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

6 - Where Can I Get Help with My Questions?

If you have questions about your Medicare home health care and you are in the Original Medicare Plan, call your Regional Home Health Intermediary. If you have questions about home health care and you are in a Medicare Advantage Plan, call your plan. If you are covered by another kind of health insurance, call the insurance company's member services office.

Every State and territory, plus Puerto Rico, the Virgin Islands, and the District of Columbia, has a State Health Insurance Assistance Program (SHIP) with counselors who will give you free health insurance information and help.

The SHIP counselors will be able to answer your questions about home health care and what Medicare, Medicaid, and other types of insurance pay for. In addition, these counselors will help you with Medicare payment questions; questions on buying a Medigap (Medicare Supplement Insurance) policy, or long-term care insurance; concerns about payment denials and appeals; Medicare rights and protections; complaints about your care or treatment; or choosing a Medicare health plan.

You can get local telephone numbers for the organizations that can help you on the "Helpful Contacts" section of the www.medicare.gov website. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in blue are defined on pages 26–27.

7 - Words to Know

Appeal
An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services, or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare health plan or the Original Medicare Plan must use when you ask for an appeal.

Assignment
In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Caregiver
A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

Durable Medical Equipment (DME)
Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for either under Medicare Part A or Part B for home health services.

Home Health Agency
An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

Long-Term Care Ombudsman
An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems between residents and nursing homes or assisted living facilities. They may be able to provide information about home health agencies in their area.

Medicare
The Federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan
A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain conditions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans. They include Medicare Managed Care Plans, Medicare Preferred Provider Organizations, and Medicare Private Fee-for-Service Plans.

Medicare-Approved Amount
The fee Medicare sets for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

7 - Words to Know

Medicare Managed Care Plan
These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization (PPO)
A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the plan's list (network). You can use doctors, hospitals, and providers outside of the network for additional cost.

Medicare Private Fee-for-Service Plan
A private insurance plan that accepts people with Medicare. You may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay for the services you get. You may pay more for Medicare-covered benefits or you may have extra benefits the Original Medicare Plan doesn't cover.

Occupational Therapy
Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after illness.

Original Medicare Plan
A fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (hospital insurance) and Part B (medical insurance).

Physical Therapy
Treatment of the patient's illness or injury by mechanical means, such as heat, light, exercise, and massage.

Provider
A doctor, hospital, health care professional, or health care facility.

Quality Improvement Organization
Groups of practicing doctors and other health care experts. They are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service Plans, and ambulatory surgical centers.

Regional Home Health Intermediary
A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

Skilled Nursing Care
A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Speech-Language Therapy
Treatment to regain and strengthen speech skills.

State Health Insurance Assistance Program (SHIP)
A State program that gets money from the Federal Government to give free health insurance counseling to people with Medicare.

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